STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445391	A. BUILDING _____ B. WING _____	05/11/2016

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MANCHESTER HEALTH CARE CENTER	395 INTERSTATE DRIVE MANCHESTER, TN 37355

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F 000	INITIAL COMMENTS During the annual Recertification survey conducted on May 9 - 11, 2016, at Manchester Health Care Center, complaints #37272, 37686, 37732, 37765, 37834, 37989, 38274, 38632, and 38750 were investigated. Complaints #37686 and 38632 were unsubstantiated and no deficiencies were cited in relation to the complaints under 42 CFR PART 483, Requirements for Long Term Care Facilities.	F 000		
F 201 SS=D	483.12(a)(2) REASONS FOR TRANSFER/DISCHARGE OF RESIDENT The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; The safety of individuals in the facility is endangered; The health of individuals in the facility would otherwise be endangered; The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or	F 201	F201 - REASONS FOR TRANSFER/ DISCHARGE A. With respect to the Specific Residents Cited: Resident #108 was assessed and interviewed by Director of Risk Management (DRM) on 05/24/16 for any concerns related to the cited deficiency and no further concerns were expressed or identified. B. With Respect to How the Facility will identify Residents with the Potential for the Identified Concern and Take Corrective Action: Residents have the potential to be affected by the deficient practice allegation of failure to follow facility standards regarding the provision of honoring a resident's appeal to an involuntary discharge. An audit done by the medical records manager of any resident that may have appealed an involuntary discharge within the previous 12 months was performed by 06/05/16 and no other instance were found. On 05/25/16, the Administrator (ADM) was re-educated by The Director of Risk Management (DRM) on facility standards on resident rights for requesting an appeal for involuntary discharge. C. With Respect to What Systemic Measures have been put in place to address the Stated Concern: By 06/15/16, the Nurse Educator (NE) or designee re-educated facility nursing management, applicable social services staff and administrator on facility standards regarding honoring a resident's appeal to an involuntary discharge. Newly hired clinical, management and social services staff will	06/15/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stephen D. Dunson | TITLE: Administrator | (X6) DATE: 06/06/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 201	Continued From page 1 The facility ceases to operate. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility document review, and interview, the facility failed to honor a resident's appeal to an involuntary discharge and the facility refused to readmit the resident to the nursing home for 1 (Resident #108) of 3 discharged residents reviewed. The findings included: Medical record review revealed Resident #108 was admitted to the facility on 3/5/13, discharged from the facility on 1/1/16 to the hospital, readmitted to the facility on 1/8/16, discharged from the facility to the hospital on 2/5/16, and readmitted to the facility on 2/12/16 with diagnoses including Abdominal Pain, Intestinal Obstruction, Elevated White Blood Cell Count, Nausea and Vomiting, Acute Kidney Failure, Chronic Kidney Disease Stage 4, Hypertension, Gastro-Esophageal Reflux Disease, Pleural Effusion, Open Wound Abdominal Wall, Pancreatitis, Obsessive-Compulsive Disorder, Suspected Carrier Methicillin Resistant Staphylococcus Aureus, Anxiety Adjustment Disorder, Psychosis, Major Depressive Disorder, Opiod Dependence, and Chronic Pain. Medical record review of the 5 day Minimum Data Sets dated 1/15/16 and 2/19/16, both were after the readmissions to the facility, revealed the resident was cognitively intact. Medical record review of the nursing note dated	F 201	receive this education during the orientation process and at least annually. The Administrator/designee will discuss the involuntary discharge process including the appeals process, with the resident and/or their responsible party immediately after any notice of involuntary discharge is given. The Inter-disciplinary Team (IDT) will review any appeal for any involuntary discharge after it is submitted at the next stand-up meeting, Monday through Friday. The Social Worker (SW) or designee will log any appeal into the grievance log along with documentation of the appeal and IDT discussions and intervention plans. The Administrator (ADM) will audit involuntary discharge notification for proper compliance, including discussions of the discharge and appeal process, five times per week for 12 weeks using the QAPI Daily Stand-up Meeting form. The Manager on Duty (MOD) will audit on weekends and notify the ADM of any appeals. Issues are immediately reviewed by the IDT for appropriate corrective actions. The ADM reports the results of the audit(s) to the Quality Assurance Committee (QAPI). D. With Respect to How the Plan of Corrective Measures will be monitored: Resident grievances, concerns or any observations of sub-standard care delivery are addressed immediately by staff receiving or observing the matter, interventions initiated and documented by the staff as necessary. The documentation is reviewed and discussed Monday through Friday in the morning meeting by the facility Administrator (ADM) Social Services Director/ designee and DON. Concerns are immediately reviewed by the ADM for appropriate corrective actions. The DON/designee reviews the concern to determine if they have been properly documented and investigated and if it needs to be reported per state and facility standards.	06/15/16

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F 201	Continued From page 2 1/8/16 at 5:21 PM revealed "...A phone call made to the administrator, on speaker phone,...that he [resident] would be receiving a written 30 day discharge letter on Tuesday, January 12th..." Review of the facility document Nursing Facility Notice of Transfer or Discharge form with the "...Date notice is given January 12, 2016...Date of Transfer/Discharge February 11, 2016..." revealed the resident "...refused to sign 1/12/16..." Review of a document provided by the facility dated 2/5/16 revealed Resident #108 filed for an appeal hearing to the involuntary discharge. Review of the document provided by the facility from the state agency dated 2/19/16 revealed the appeal hearing request had been timely appealed and a hearing date was specified. Medical record review of a nursing note dated 2/5/16 revealed the resident had been discharged from the facility to the hospital. Medical record review of the hospital Psychiatry Consult Final Report dated 2/10/16 revealed "...While here,...notified by administrator [of named nursing home] where the patient has lived for the past four years, they are declining to accept patient back at discharge...that their facility would continue to pursue eviction regardless..." Interview with the Administrator, on 5/11/16 at 3:10 PM in his office revealed when asked if after the resident had filed the appeal for involuntary discharge and was then discharged to the hospital did he (Administrator) contact the	F 201	The ADM/DON also report the results of incidents/investigations review to the Quality Assurance Performance Improvement (QAPI) Committee made up of the Medical Director, rehab manager, social services director, dietary/registered dietitian, activities director, DON, unit managers from nursing, resident financial coordinator, restorative nurse, medical records director, or designated subcommittee. QAPI meetings occur monthly. The facility ADM will chair the QAPI committee. Any aberrancy reported has interventions developed and appropriate actions taken by the ADM/DON in conjunction with the QAPI Committee. This includes but is not limited to in-services for the appropriate staff, a review of facility standards that relate to the aberrant practice, tracking/trending of concerns to identify root cause factors and implement preventive interventions and ongoing monitoring to assure the deficient practice does not recur. The ADM/DON in conjunction with the QAPI committee also reviews facility standards that relate to the aberrant practice and completes ongoing monitoring to assure the deficient practice does not recur. When current interventions are not producing the desired outcome or resolution to prior issues, the ADM/DON in conjunction with the QAPI committee develop alternate interventions including employee training programs, employee competency testing for compliance, until the desired outcome is achieved, that all incidents are investigated thoroughly and reported to the state agency per facility standards/state requirements.	06/15/16

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F 201	Continued From page 3 hospital to state the facility would not accept the resident back in the facility, the Administrator confirmed he "... had called the hospital to inform them the facility chose not to take the resident back to the facility..." Further interview revealed when asked if he was aware he could not proceed with the discharge after the appeal was filed stated "...I didn't know that..."			
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observation, and interview the facility failed to instruct resident prior to use and failed to follow manufacturer's recommendations after use of inhalants for 1 (Resident #101); failed to ensure a resident took the prescribed amount of an inhalant for 1 (Resident (#133) of 4 residents observed for medication administration, and failed to document turning and repositioning of 1 (Resident #139) of 47 residents reviewed. The findings included: Medical record review revealed Resident #139 was admitted to the facility on 5/5/15 and readmitted on 9/22/15 with diagnoses including Cerebrovascular Accident with Cognitive Deficit, Depression, Cervical 5-7 Quadriparesis, Hypertension, and Diabetes Mellitus. Medical record review of a Quarterly MDS dated	F 281	F281 - SERVICES PROVIDED MEET PROFESSIONAL STANDARDS A.With respect to the Specific Residents Cited: It is the policy of the facility to provide residents with adequate care and supervision so as to minimize any type of physical or mental injury. Resident #139 no longer resides at the facility. Residents #101 and #133 were assessed by the Nurse Educator (NE) 05/18/16, to identify any adverse effects from the cited deficiency and no issues were identified. B.With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action: Residents have the potential to be affected by the deficient practice allegation of failure to follow facility standards regarding providing services by a qualified person and/or per the resident's plan of care. By 06/15/16, a general audit of care delivery practices by aides, including observations of transfer and positioning practices with review of corresponding documentation will be completed by the DON/designee had assessed residents who required extensive assistance for their ADL self-care and were dependent on staff for turning and positioning in order to ensure that they had been properly cared for by using the "QAPI Daily Focused Rounds Form" as an audit tool. No negative findings were found nor were concerns about positioning voiced by any of the residents. An audit of medication administration practices of facility, including policies and procedures regarding inhalers and resident self-administration by facility nurses was done through 05/30/16 by the NE/DON/designee. Any issues identified were immediately corrected by the auditor.	06/15/16

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F 281	Continued From page 4 1/14/16 revealed Resident #139 scored 1/15 on the Brief Interview for Mental Status, indicating the resident was severely cognitively impaired. Continued review of the MDS revealed Resident #139 was dependent on 2 people for transfers, toileting, and bathing; required extensive assistance of 2 people for dressing and grooming; required extensive assistance of 1 person for eating; and was always incontinent of bowel and bladder. Medical record review of the Follow Up Question Report for March 2016 revealed documentation on 3/15/16, Resident #139 was turned and repositioned at 00:30 (12:30 AM) and again at 8:15 AM. Continued review of the report as well as review of nursing notes for 3/15/16 revealed no further documentation of Resident #139 being turned and repositioned. Review of the facility policy "...Oral Inhalation Policy..." revealed "...instruct the resident to inhale slowly as you depress the canister to release medication...have resident rinse his/her mouth and spit out the rinse water..." Medical record review revealed the resident #101 was admitted to the facility on 11/11/15 with diagnoses including Congestive Heart Failure, Atrial Fibrillation, and End Stage Renal Disease. Review of the resident Physician recapitulation orders for May 2016, revealed "...Advair Discus (type of inhaler) 1 puff inhale orally..." Observation of Charge Nurse #2 on 5/9/16 at 8:49 PM, in the resident's room, revealed the Charge Nurse administered the Advair and failed	F 281	C. With Respect to What Systemic Measures have been put in place to address the Stated Concern: By 06/15/16, certified nursing assistants (CNAs) will be re-educated by the Nurse Educator (NE) or designee on providing services per physician orders and per the resident's plan of care, including the provision of transfers, position and turning. This education included proper care for residents dependent on nurses or CNAs for their care, documenting the care and notification of their supervisor whenever required care was not done for any reason. The NE/designee will observe care practices of at least one CNA staff member each weekday for 12 weeks, using the audit tool, "QAPI Daily Focused Rounds Form" to document that positioning, turning and transfers are being done per physician order and facility standards and properly documented. Issues will be immediately addressed, corrected as necessary and reported to the DON/designee. By 05/30/16, Department Managers (DM) and nurse managers were re-educated by the DRM regarding observing and reporting any concerns of aides not providing care as specified in the care plan, including turning and positioning and transfers and documenting those care practices on the residents medical record. The DM's will observe practices during their daily rounds using the "Survey Preparedness Rounds " form and report any issues during the daily standup and stand down meetings. These audits will be conducted 5 times per week for 12 weeks. By 06/10/16 Charge Nurse #2 and #3 were interviewed and counseled by the DON/designee on facility standards regarding medication administration, including policies and procedures regarding inhalers, observation of a resident receiving inhalation therapy and resident self-administration of medications. By 06/12/16, the NE/designee had observed Charge Nurse #2 and Charge Nurse #3 medication administration	06/15/16

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F 281	Continued From page 5 to give instruction on medication use prior to administration, and failed to instruct to rinse the mouth after use. Interview with the Charge Nurse on 5/9/16 at 8:55 PM, on the 100 hall, confirmed the facility policy for inhalation administration was not followed. Medical record review revealed resident #133 was admitted to the facility on 4/14/16 with diagnoses including Chronic Obstructive Pulmonary Disease, Heart Failure, and Obstructive Sleep Apnea. Observation on 5/11/16 at 7:41 AM revealed Charge Nurse #3 administering medications. Continued observation revealed the Charge Nurse walked into resident #133's room to administer a breathing treatment and walked out of resident room while breathing treatment was still running. Interview with Charge Nurse #3 on 5/11/16 at 7:50 AM, on the 300 hall, confirmed the resident was left unattended while the breathing treatment was still in progress, and confirmed the resident was not assessed for self-administration of medications. Interview with the Director of Nursing (DON) on 5/11/16 at 2:02 PM, in the DON office, confirmed the facility policy for inhalation therapy was not followed for resident #101 and #133. During interview on 5/11/16 at 3:00 in the conference room, the Director of Nursing confirmed there was no documentation Resident #139 had been turned on 3/15/16.	F 281	practices, including the use of inhalation medication standards and documented the results on the "QAPI Daily Focused Rounds Form" to ensure that medication administration is being done per physician order and properly documented. By 06/15/16, nursing staff were re-educated on facility standards regarding medication administration, including policies and procedures regarding inhalers and resident self-administration of medications. The education included the continuous observation of residents during inhalation treatments and ensuring the resident rinse their mouth out after inhaler administration. Newly hired clinical staff will receive this education by the NE/designee during the orientation process and annually. The NE/designee will observe care practices of clinical staff weekdays and document issues, using the audit tool, "QAPI Daily Focused Rounds Form" to evaluate clinical competencies of at least one nursing staff member daily to ensure that medication administration practices, including inhalation therapy practices are being done per physician order and facility standards and properly documented daily x 12 weeks. Any negative findings are reported to the DON/ designee. Issues will be immediately addressed and corrected as necessary. D. With Respect to How the Plan of Corrective Measures will be monitored:The DON or designee reviews the results of the audits. Reported concerns will have interventions developed and appropriate actions taken by the ADM in conjunction with the QAPI Committee. When current interventions are not producing the desired outcome or resolution to prior issues, the ADM in conjunction with the QAPI committee will develop alternate interventions until compliance is achieved.	06/15/16

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F 309 F 309 SS=D	Continued From page 6 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to follow the physician orders for daily fasting blood sugars for 1 (Resident #48) of 47 residents reviewed. The findings included: Medical record review revealed Resident #48 was admitted to the facility on 2/22/16, discharged from the facility to the hospital on 3/29/16; readmitted to the facility on 4/4/16, discharged from the facility on 4/22/16 Against Medical Advice with diagnoses including Urinary Tract Infection, Altered Mental Status, Hypothyroidism, Orthostatic Hypotension, Osteoarthritis, Edema, Pneumonia, Systolic Congestive Heart Failure, Hyperkalemia, Hypoglycemia, Dehydration, Obesity, and Disorder of Kidney and Ureter. Medical record review of the Physician Telephone Order dated 2/23/16 revealed "...Fasting Blood Sugars Daily @ [at] 6AM..." Medical record review of the 2/2016 Medication Administration Record, nursing progress notes,	F 309	F309 - PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING A. With respect to the Specific Residents Cited: A physical assessment and medical records documentation review was provided for resident #48 by DON/designee on 05/12/16 to validate physician prescribed orders for blood sugars were being done as ordered and properly documented and the resident/MD/ responsible party was notified. No other issues were identified. B. With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action: Residents have the potential to be affected by the deficient practice allegation of failure to follow facility standards regarding providing diagnostics as prescribed by a physician. An audit of blood glucose monitoring practices, including documentation of care by facility nurses was done through 06/15/16 by the Unit Manager and DON/designee. Any issues identified were immediately corrected by the UM or DON/designee. C. With Respect to What Systemic Measures have been put in place to address the Stated Concern: By 06/15/16, licensed staff were re-educated by the DON or designee on following per physician orders, including obtaining blood glucose levels and documenting results in the medical record. Newly hired clinical staff will receive this education during the orientation process and at least annually. The NE/designee will observe care practices of clinical staff weekdays and document issues using a "Quality Assurance Review Audit" form for 12 weeks. The Nursing Management team will perform observation audits, using the audit tool, "QAPI Daily Focused Rounds Form" to ensure that blood glucose monitoring is being done per physician order and properly documented daily x 12 weeks. Any negative	06/15/16

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F 309	Continued From page 7 skilled nursing notes, and the Blood Sugar form, revealed the facility failed to obtain and/or document fasting blood sugar results on 2/24/16, 2/25/16 and 2/26/16. Interview with the Director of Nursing on 5/11/16, at 4:21 PM on the 100 hall confirmed the facility did not have Fasting Blood Sugars for 2/24/16 through 2/26/16.	F 309	findings are reported to the DON/designee. D. With Respect to How the Plan of Corrective Measures will be monitored: Issues and practice concerns will have appropriate action plans and interventions developed by the ADM/DON in conjunction with the QAPI Committee. Interventions include in services for the licensed nursing staff, a review of facility policies and procedures that relate to the aberrant practice and ongoing monitoring to assure the deficient practice does not recur. When current interventions are not producing the desired outcome, the ADM/DON in conjunction with the QAPI committee will develop alternate interventions until compliance is achieved.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, facility investigation review, and interview, the facility failed to determine the bed alarm functioned properly for 1 (Resident #71); failed to follow facility policy for documentation after an elopement for 1 (Resident #128); and also failed to document staff training for use of a lift for 1 (Resident #119) of 47 residents reviewed. The findings included: Medical record review revealed Resident #71 was admitted to the facility on 6/8/15 and readmitted on 2/15/16 with diagnoses including Parkinson's Disease, Hypertension, Pacemaker Insertion,	F 323	F323 - FREE OF ACCIDENTS HAZARDS/ SUPERVISION/DEVICE A. With respect to the Specific Residents Cited: It is the policy of the facility to provide residents with adequate care and supervision so as to minimize any type of physical or mental injury. On 05/13/16 resident #71's bed alarm was checked by the NE and found to be functioning properly. By 05/30/16, the DON or designee assessed residents # 71, #119 and #128 for any adverse effects related to the cited deficiencies. No negative findings were found. B. With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action: All residents have the potential to be affected by the deficient practice allegation of failure to follow facility standards regarding safety devices (including bed alarms), lifts and transfers and elopement protocols. An audit using a "QAPI Focused Rounds Form" was completed for residents with alarms devices by the nurse management team on 06/15/16 and all alarms were functioning properly. By 06/15/16, a general audit of lift transfer	06/15/16

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F 323	Continued From page 8 Dementia, Gastroesophageal Reflux Disease, and Degenerative Disc Disease. Review of the Quarterly Minimum Data Set dated 3/4/16 revealed Resident #71 scored 1 on the Brief Interview for Mental Status, indicating the resident was severely impaired cognitively. Continued review of the MDS revealed Resident #71 required extensive assistance of one person with transfers, eating, dressing, and toileting; was dependent on one person for grooming and bathing; was frequently incontinent of bladder and was always incontinent of bowel. Medical record review of nursing notes dated 8/2/15 revealed the Certified Nurse Aide (CNA) answered the resident's call light and found the resident sitting on the floor next to the bed with the back against the wall. Continued review revealed the resident sustained a skin tear 3 cm (centimeters) on the left (lt) elbow as well as bruising lt. wrist, and hematoma above lt. eye. Further review revealed Resident #71 was transferred to the hospital where testing showed she had suffered a subdural hematoma and fracture of the lt. wrist. Review of the facility investigation dated 8/2/15, revealed "...Call light was on - tech went to answer light and saw resident lying on the floor next to her bed - her back was against the wall and her knees were bent and facing foot of bed - blood was noted on the floor next to resident - skin tear approx (approximately) 3 cm (Centimeters) in length was noted on left elbow - blood noted on lt. eyebrow area with swelling and bruising already present - resident c/o (complained of) pain in left wrist area - resident has arthritis and unable to determine if wrist is	F 323	competencies of Certified Nurses Assistants (CNA's), including CNA #11, was completed by the DON/designee. By 06/15/16, all clinical staff were re-educated on facility standards for lift transfers. By 06/15/16, the DON/Designee had assessed residents who required extensive assistance for their ADL self-care and were dependent on staff for turning and positioning in order to ensure that they had been properly cared for by using the "QAPI Daily Focused Rounds Form" as an audit tool. No negative findings were found nor were concerns about transfers voiced by any of the residents. C. With Respect to What Systemic Measures have been put in place to address the Stated Concern: In-Servicing on facility standards for personal safety alarms, elopement documentation and lift transfers was completed by the NE and DON/designee to clinical staff by 06/15/16. The re-education included how and when to verify personal alarm function, facility standards for use of lifts and the facility "No-Lift" program as well as the elopement/wandering standard which requires safety checks per protocol following exit seeking behaviors. Newly hire clinical staff will receive in-service education on these policies and protocols during orientation and annually. The Nurse Educator/ designee is responsible for in-services regarding these facility standards and documentation of staff education on them will be maintained in the employee record. D. With Respect to How the Plan of Corrective Measures will be monitored: Issues and practice concerns will have appropriate action plans and interventions developed by the ADM/DON in conjunction with the QAPI Committee. Interventions include in services for the licensed nursing staff, a review of facility policies and procedures that relate to the aberrant practice and ongoing monitoring to assure the deficient practice does not recur.	06/15/16

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F 323	Continued From page 9 distorted - resident unable to grip with left hand and bruising and swelling already present - unable to explain why she was getting out of bed - tech noted bed alarm was not going off while resident was out of bed - bed alarm did beep when resident was placed in bed..." Continued review of the report revealed no documnetation the bed alarm was changed and inspected since it had not been sounding when the resident got up from the bed. Interview with the Charge Nurse confirmed the bed alarm was not sounding when the resident exited the bed but it was documented the alarm had been tested during the shift and was functioning properly. Medical record review revealed resident #119 was admitted to the facility on 7/24/15 with diagnoses including Dementia, Cognitive Communication Deficit, Osteoarthritis, Essential Hypertension, Cardiac Arrhythmias, Chronic Kidney Disease, Anxiety Disorder, Chronic Pain, Aphasia, Hypothyroidism, and Insomnia. Review of the facility policy, Body Mechanics & [and] Transfers undated 2013 revealed "...important point to be made is how to safely perform a transfer for the resident and staff member...In order to protect your resident and yourself, you must know how much the resident can assist you in the transfer...Know the most efficient and safest way to transfer a resident..." Review of the facility policy, Falls Standard updated 11/14 revealed "...The facility strives to reduce the risk for falls and injuries...Provide	F 323	When current interventions are not producing the desired outcome, the ADM/DON in conjunction with the QAPI committee will develop alternate interventions until compliance is achieved.	06/15/16

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F 323	Continued From page 10 training to staff as appropriate..." Medical record review of the Care Plan dated 7/24/15, revealed Resident #119 was care planned for risk for falls. Continued review of updated Care Plan dated 12/5/15 revealed "...educated CNA [Certified Nurse Aide] regarding appropriate use of lifts..." Medical record review of a Minimum Data Set (MDS) dated 10/26/15, revealed Resident #119 scored a BIMS (Brief Interview for Mental Status) of 3 out of 15, indicating the resident was severely cognitively impaired. Continued review revealed the Resident was an extensive assist, required 1 person physical assist with transfers and she was able to stabilize with staff assistance. Medical record review of Order Summary Report dated 12/2/15 revealed "...Sit to stand lift with 1-2 assist..." Medical record review of Nursing Progress Note dated 12/5/15 revealed "...Resident slid out of sit-to-stand during transfer landing on floor...first aid completed..." Medical record review of the Record of Counseling dated 12/5/15 revealed "... CNA inserviced on: make sure all straps, buckels [buckles] in place and lift in functioning manner before lifting resident...CNA assisting resident to bed in a sit-to-stand lift..." Medical record review of Witnessed Fall dated 12/5/15 revealed "...Upon entering room this nurse noted resident lying in floor...Resident had small amount of bleeding...to back of	F 323		

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F 323	Continued From page 11 head...purple bruise to left forearm...pink superficial abrasion...to mid back...strap on sling around chest was not buckled...CNA inserviced on proper use of lift and safety and making sure lift in complete functioning manner prior to lifting resident..." Medical record review of Physician Telephone Order dated 12/5/15 revealed "...Apply triple antibiotic ointment to abrasion on back of head q shift [every shift] until resolved...Cleanse skin tear to LFA [Left Forearm] c [with] wound cleanser, apply skin prep to surrounding tissue, apply xeroform gauze...cover with transparent drsg [dressing]..." Medical record review of PT (Physical Therapy) Progress Note dated 12/7/15 revealed "...pt [patient] fell while using sit to stand lift with staff on 500 hallway...[CNA #11] has received retraining on use of sit to stand...If staff cannot find second assistant and patient is uncooperative with care, Hoyer may be used for safety..." Interview with CNA #11 who was involved in the accident, on 5/10/16 at 4:29 PM on the 100 hall, confirmed "...The resident [Resident #119] was going to bed... I didn't have anyone to help me...She hit her head on chair and floor... She had blood coming from back of head...They were in middle of shift change when it happen...I called for help...your supposed to have two people...She fell straight back...I think I was trained...After fall I was educated on transfers using the lift..." Interview with Assistant Director of Nursing on 5/11/16 at 9:21 AM, in dining room, confirmed there is no syllabus for education provided prior to	F 323		

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F 323	Continued From page 12 12/5/15 to indicate that CNA #11 was trained in transfers. Interview with the Restorative Nurse #1 on 5/11/16 at 1:29 PM, at the nursing station, confirmed "...I don't see her name on in-services sign in forms..." Interview with Director of Nursing (DON) on 5/11/16 at 1:38 PM, in the DON's office, confirmed there is no documentation indicating CNA #11 received transfer device training prior to fall on 12/5/15 and the resident did not require outside medical attention. Review of the facility policy dated 5/15 entitled Wandering/Elopement, revealed, "...If a resident exhibits wandering behavior...exits the building...resident returned...1 to 1 staff safety checks...implemented...behavior subsides...30 minute checks...4 hours...60 minute checks...4hours..." Medical record review revealed Resident #128 was admitted to the facility on 01/16/14 and re-admitted on 10/23/15, with diagnoses of Muscle Weakness, Alzheimer's disease, Anxiety Disorder, Cognitive Deficit following Cerebrovascular Disease, Dementia with Behavioral Disturbance, Hallucinations, Mood Disorder, Delusions Disorders, Extrapyramidal and Movement Disorder, Degenerative Disease of Nervous System, History of Falling, Chronic Pain and Insomnia.	F 323		

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F 323	Continued From page 13 Medical record review of the nurses progress note dated 8/15/15 revealed that Resident #128 was able to get out of the building by a visitor who held the door open and was seen by staff in the parking lot. CNA was able to get the resident back into the building safely without incident. Resident has Dementia and is unaware most times of her surroundings. Resident was assessed and had no injuries. Medical record review revealed the facility did not follow their policy by failing to document 1 to 1 staff safety checks until exit seeking behavior subsided then 30 minutes safety checks for 4 hours and then 60 minute safety checks for 4 hours after the resident was returned to the facility after the incident. Interview with the Assistant Director of Nursing (ADON) on 5/11/16 at 9:03 AM in the 500 hallway confirmed there was no documentation of 1 to 1 staff safety checks until exit seeking behavior subsided then 30 minutes safety checks for 4 hours and then 60 minute safety checks for 4 hours as stated in the Wandering/Elopement Policy.	F 323		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient	F 353	F353 - SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS A. With respect to the Specific Residents Cited: It is the policy of the facility to provide residents with adequate care and supervision so as to minimize any type of physical or mental injury. Current residents cited under this tag were assessed by the Nurse Educator (NE) and DON/designee by 6/09/16, to identify any adverse effects from the cited deficiencies and no issues were identified.	06/15/16

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F 353	Continued From page 14 numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, observation, and interview, the facility failed to provide sufficient staff to meet the needs of the residents in a timely manner for 6 residents (#4, #129, #114, #44, #141,and #181) of 23 interviewable residents who were dependent for needs, of 47 residents reviewed and failed to ensure medications were administered timely for 17 residents of 22 residents reviewed on 1 of 5 hallways. The findings included: Medical record review revealed Resident #4 was admitted to the facility on 5/23/15 with diagnoses of Diabetes Mellitus Type 2, Dysphasia, Coronary Artery Disease, Hypertension, Peripheral Vascular Disease, Mood Disorder, Atrial Fibrillation, and Acquired Absence of Left Leg above the Knee. Medical record review of Resident #4's Minimum	F 353	On 05/11/16, the DON verified that staffing on all halls met or exceeded facility standards and/or state requirements. By 06/15/16, residents #4, #129, #114, #44, #141,and #181 who are dependent for needs, were interviewed and assessed by the DON/ designee for any adverse affects related to insufficient staffing levels. By 06/15/16 a discussion of staffing was done with each of these residents and each was given details of how to report any concern they may have on staffing or any other issue that may affect them in the facility. Any concerns or issues were documented on a "Concern & Grievance" form and followed up per facility standards for resolving concerns. The residents were told that reporting could be to any staff member and/or to the Department Manager that visits with them weekdays with the expectation that all concerns will be addressed and resolved to their satisfaction. They may also request a discussion with the DON and/or ADM whenever desired. The 17 residents that were cited as having medications not delivered in a timely manner were assessed by the NE and UM on 5/11/16, with non adverse effects noted. The attending MD was notified and all medications were administered per physician orders. The Unit Manager (UM) assisted in the medication administration of these residents on 05/11/16 after notification by the surveyor. The residents responsible party was notified of the delay by 05/30/16.	06/15/16

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F 353	Continued From page 15 Data Set (MDS) annual assessment dated 4/5/16 revealed the resident scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating the resident was independent with daily decision making, required extensive assistance with a 2+ person physical assist for bed mobility, transfers, toileting and personal hygiene. Interview with the resident on 5/9/16 at 2:20 PM, in the resident's room, revealed the resident stated "...it took a long time for the staff to answer lights..." Medical record review revealed Resident #129 was admitted to the facility on 1/28/16 with diagnoses of Muscle Weakness, Adult Failure to Thrive, Diabetes Mellitus Type 2, and Anemia. Medical record review of Resident #129's MDS 14 day assessment dated 2/11/16 revealed the resident scored 15 out of 15 on the BIMS, indicating the resident was independent with daily decision making, required limited assistance with a 1 person physical assist for bed mobility, transfers, toileting, and personal hygiene. Interview with Resident #129 on 5/10/16 at 7:34 AM in the resident's room revealed when asked if the facility had enough staff to meet her needs without waiting for a long time stated "...at night at 11:00 PM not enough staff, I press the call light and not get a response for a long time..." Further interview revealed when asked how long was a long time the resident stated "...I don't check my watch I just got to go to the bathroom..." Further interview revealed when asked if the facility staff ever came to her room to answer the call light and told her they would be back in a minute she stated "...Yes...Sometimes they didn't come	F 353	B. With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action: Residents have the potential to be affected by the deficient practice allegation of failure to follow facility standards regarding sufficient staffing and providing medications administered as prescribed by a physician. An audit of staffing ratios on all halls and medication pass compliance was done on 05/11/16 by the ADM and DON/designee. Any issues identified were immediately corrected by the ADM or DON/designee. On 05/11/16, the Unit Manager assisted with medication administration on the 300 hall. C. With Respect to What Systemic Measures have been put in place to address the Stated Concern: By 06/15/16, clinical staff were re-educated by the DON or designee on 24 hour clinical staffing requirements for each shift and hall. Education included the requirement that staff immediately reports any deficiencies in staffing to a supervisor and the supervisor will take corrective actions to maintain mandated staffing levels. If corrective actions cannot be done in a timely manner, the supervisor will contact the DON and/or ADM so they can correct the deficiency and the supervisor will assist in whatever capacity necessary to ensure adequate care delivery in the area with the staffing need. The DON or ADM will immediately assist in securing staff to ensure staffing levels that meet or exceed facility and/or state standards. Department managers may be called in to assist in care delivery as needed.	06/15/16

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F 353	Continued From page 16 back..." Further interview revealed when asked when the facility staff told her to wait a minute and didn't come back did she have something happen she stated "...I had to go on myself..." Further interview revealed when asked how she felt when she had to go on herself she stated "...It didn't make me feel good that's for sure..." Medical record review revealed Resident #114 was admitted to the facility on 1/21/16 with diagnoses of Muscle Weakness, Dementia, hematemesis, Acute Embolism and Thrombosis of Unspecified Deep Veins of Lower Extremity, and Acute Bronchitis. Medical record review of Resident #114's MDS quarterly assessment dated 2/18/16 revealed the resident scored 15 out of 15 on the BIMS, indicating the resident was independent with daily decision making, required extensive assistance with a 2+ person physical assist for bed mobility, transfers, toileting and personal hygiene. Interview with the resident on 5/9/16 at 2:35 PM in the resident's room revealed the resident stated "... the staffing of Nurses and CNAs was insufficient on all shifts..." Medical record review revealed Resident #44 was admitted to the facility on 3/3/15 with diagnoses of Parkinson's Disease, Dysphasia, Symbolic Dysfunctions, and Presence of cardiac Pacemaker, Major Depressive Disorder, Anxiety and Chronic Kidney Disease. Medical record review of Resident #44's MDS annual assessment dated 2/12/16 revealed the resident scored 0 out of 15 on the BIMS, indicating the resident was cognitively impaired	F 353	The DON and/or ADM will verify staffing prior to each shift and take actions necessary to ensure staffing level met or exceed facility and/or state standards. In May of this year, the facility started a state approved, ongoing training course for CNA's which may provide a pool of nursing assistant staff available to meet the care needs of facility residents. On 5/11/16 LPN #3 was interviewed and counseled by the DON and NE on medication administration practices (including the requirement to administer medications per the physician ordered times). On 05/11/16, the NE observed LPN #3 medication administration practices and documented the results on a "Medication Pass Observation" form to ensure that medication administration is being done per physician order and properly documented. On 5/11/16 Charge Nurse #1 was interviewed and counseled by the DON and NE on medication administration and infection control practices (including the requirement to use the in-house MedSelect system and/or backup pharmacy when a resident medication is not available and never use another resident's medication). On 05/12/16, the NE observed Charge Nurse #1 medication administration practices and documented the results on the "QAPI Daily Focused Rounds Form" to ensure that medication administration is being done per physician order and properly documented. By 06/15/16, licensed nursing staff were re-educated on facility standards regarding medication administration, including timely administration of medications, notification of a nursing supervisor if unable to administer timely and MD notification when medications are not administered per physician order.	06/15/16

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F 353	Continued From page 17 with daily decision making, required extensive assistance with a 2+ person physical assist for transfers and toileting. The resident's daughter states that when she or other family comes to visit in the evenings that there never seems to be enough help (CNAs). On several occasions the resident's daughter will visit with other residents that she knows here and the same thing happens regarding timeliness in having call lights answered. Medical Record review revealed Resident #141 was admitted to the facility on 6/15/15 with diagnoses of Alzheimer's Disease, Dementia, Dysphasia, Atrial Fibrillation, Hypertension, Insomnia, Migraine with Aura, and Anemia Medical record review of Resident #141's MDS quarterly assessment dated 3/22/16 revealed the resident scored a 0 out of 15 on the BIMS, indicating the resident was severly cognitively impaired with daily decision making, required extensive assistance with a 2+ person physical assist for bed mobility, transfers, toileting and personal hygiene. Interview with the resident's daughter on 5/11/16 at 12:05 PM, in the conference room, revealed the daughter was very upset about the staffing at the facility, the daughter's mother (Resident # 141) had only one CNA on her hall who would have to split her duties with another hall and the Nurse that took care of her mother also had to work on 2 halls and did not have enough time to take care of her mother properly. The daughter stated the resident had been found several times incontinent with feces or urine in her brief and the room smelled badly as a result. The daughter	F 353	Newly hired clinical staff will receive this education upon orientation and at least annually. The Unit Managers/designee will observe medication administration time adherence of at least one random resident daily and document issues using a "Quality Assurance Review Audit" form for 12 weeks. Any negative findings are immediately corrected and then reported to the DON/designee. The Nursing Management team will perform audits of medication times by reviewing the medical record dashboard in the daily clinical meeting and using the audit tool; "QAPI Daily Focused Rounds Form" to record issues and educate nurses that are not meeting expectations weekdays x 12 weeks. Any negative findings are immediately corrected and then reported to the DON/designee. The Pharmacy Consultant or designee will monitor monthly through monthly medication pass reviews and report findings at monthly QAPI meeting. Issues will be immediately addressed and corrected as necessary.	

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F 353	Continued From page 18 also stated the resident's bed smelled so badly that she thought it should be replaced. Medical record review revealed Resident #181 was admitted to the facility on 4/11/16 with diagnoses of Cerebral Infarction, Syncope and Collapse, Chronic Obstructive Pulmonary Disease, Hypertension, and Muscle Weakness. Medical record review of Resident #181's MDS 14 day assessment dated 4/25/16 revealed the resident scored 15 out of 15 on the BIMS, indicating the resident was independent with daily decision making, required extensive assistance with a 1 person physical assist for toileting and personal hygiene. Interview with the resident on 5/11/16 at 9:01 AM in the resident's room revealed the resident stated "...her 9:00 PM medications were given at 2:00-2:30 AM, last night and at least 3 other times in the last month. The nursing staff does not have enough nurses to perform their duties as they should..." Interview with CNA #2 on 5/10/16 at 6:20 AM on the 200 hall revealed "...no...did not feel they had enough help last night...Residents...sometimes have to wait longer than I think they should, but we get to them...we have walkie-talkies so we can find each other if we need help..." Interview with CNA #3 on 5/10/16 at 6:45 AM, at the main nursing station, revealed most of the time they are short of CNA's and the LPN's and RN's do not help them out. Interview with CNA #4 on 5/10/16 at 6:50 AM, at the main nursing station, revealed most of the	F 353	D. With Respect to How the Plan of Corrective Measures will be monitored: Issues and practice concerns will have appropriate action plans and interventions developed by the ADM/ DON in conjunction with the QAPI Committee. Interventions include in services for the licensed nursing staff, a review of facility policies and procedures that relate to the aberrant practice and ongoing monitoring to assure the deficient practice does not recur. When current interventions are not producing the desired outcome, the ADM/DON in conjunction with the QAPI committee will develop alternate interventions until compliance is achieved.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANCHESTER HEALTH CARE CENTER	395 INTERSTATE DRIVE MANCHESTER, TN 37355

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F 353	Continued From page 19 time they are short of CNAs, last weekend they only had 1 CNA and a CNA student for the whole building and the LPNs and RNs do not help them out. Interview with LPN #6 on 5/10/16 at 3:48 PM at the main nursing station revealed the staffing of CNA was not good enough, a lot of the time they split the 100 hall med cart (medication dispensing unit) "...I don't feel like we have enough staff on weekends. We would like a lot more on the 100 hall, mostly need them from 7P-7A...trying to hire 8 hour nurses. People complain about not enough staff..." Interview with CNA #10 on 5/11/16 at 6:42 AM on the 500 hall revealed she worked on the 11:00 PM to 7:00 AM shift. Further interview revealed when asked if she ever had to tell a resident I'll be back when answering a call light she stated "Yes." Further interview revealed when asked if when she went back to the resident's room were there any negative outcomes, like was the resident soiled, she stated "Yes." Further interview revealed when the CNA came on duty for the 11:00 PM shift she would find residents up at 11:00 PM and not put to bed yet "...because the 3:00 PM to 11:00 PM shift was short..." Further interview revealed CNA #10 also worked on weekends and the facility had 2 CNAs scheduled to work on weekends on the 11:00 PM to 7:00 AM shift and the nurses did not provide direct care for residents. Interview with CNA #1 on 5/11/16 at 8:55 AM, on the 200 hall revealed the facility never had enough CNAs, at most 1 per hall, the facility used to have 2 per hall which worked out well and the	F 353		

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F 353	Continued From page 20 residents were taken care of well, now they have to care for the residents short- handed and the LPNs do not offer to help or answer call lights. Interview with the administrator on 5/11/16 at 5:00 PM, in the administrator's office, confirmed the facility has had an ongoing problem with staffing. Review of facility policy, Medication Administration-General Guidelines, dated August 2012, revealed "...The facility has sufficient staff to allow administering of medications without unnecessary interruptions...Medications are administered within 60 minutes of scheduled time..." Observation with Licensed Practical Nurse [LPN] #3 on 5/11/16 at 12:30 PM, on the 300 hallway, revealed the LPN had medications sitting on top of the medication cart. Interview with LPN #3 on 5/11/16 at 12:30 PM, on the 300 hallway, confirmed she had "...given several residents their medications late this morning...this was the last resident for her AM medication pass...it has been a hectic morning...had to send a resident out to the hospital, and had to help Certified Nursing Assistants [CNA's] answer call lights and take residents to the bathroom..." Review of the Medication Administration Audit Report dated 5/11/16, Unit 300 Hall revealed 17 of the 22 residents had received there scheduled AM medications greater than 1 hour after the scheduled time. Interview with the DON on 5/11/16 at 3:30PM, at	F 353		

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F 353	Continued From page 21 the Nurses Station, confirmed the residents had not received their medications timely.	F 353		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observation, and interview the facility failed to ensure medications were obtained from the facility in house back up pharmacy for 2 (Resident #183, #184) on 1 of 3 halls observed. The findings included: Review of the facility policy "...Automated	F 425	F425 - PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH A. With respect to the Specific Residents Cited: It is the policy of the facility to provide residents with adequate care and supervision so as to minimize any type of physical or mental injury. The medical records for residents #183 and #184 were reviewed by the DON/designee on 05/12/16, to identify any adverse effects from the cited deficiency of failure to use medication for single use only on residents #183 and #184. No issues were identified, the attending MD was notified and no new orders were given and the residents/responsible parties were notified. B. With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action: Residents have the potential to be affected by the deficient practice allegation of failure to follow facility standards regarding medications administered as prescribed by a physician. A match back compliance audit of cited resident medications was done on 05/11/16 by the ADM and DON/ designee. Any issues identified were immediately corrected by the ADM or DON/ designee. C. With Respect to What Systemic Measures have been put in place to address the Stated Concern: On 5/11/16 Charge Nurse #1 was interviewed and counseled by the DON and NE on medication administration and infection control practices (including the requirement to use the in-house MedSelect system and/or backup pharmacy when a resident medication is not available and never use another resident's medication).	06/15/16

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F 425	Continued From page 22 Dispensing Machine...(not dated)" revealed, "...this machine contains medications to be used for first doses and in instances when the medication is out of stock..." Medical record review revealed Resident #183 was admitted to the facility on 5/2/16 with diagnoses including Heart Disease, Type 2 Diabetes Mellitus, and Chronic Obstructive Pulmonary Disease. Medical record review of the Physician Recapitulation orders dated May 2016 revealed "...Lantus (type of insulin) inject 70 units...at bedtime..." Medical record review revealed Resident #184 was admitted to the facility on 5/6/16 with diagnoses including Cellulitis, Type 2 Diabetes Mellitus, and Disorder of Kidney. Medical record review of the Physician Recapitulation orders dated May 2016 revealed "...Levemir (type of insulin) 30 units...at bedtime..." Observation on 5/9/16 at 8:10 PM revealed Charge Nurse #1 administering medications on the 100 hall. Continued observation revealed the Charge Nurse did not have Lantus for Resident #183 and Levemir for resident #184. Observation revealed the Charge Nurse borrowed the medications from other residents and failed to obtain the medications from the facility in house back up pharmacy. Interview and observation with the Director of Nursing (DON) on 5/10/16 at 9:02 AM, in the DON's office, revealed the facility had an	F 425	On 05/12/16, the NE observed Charge Nurse #1 medication administration practices and documented the results on the "QAPI Daily Focused Rounds Form" to ensure that medication administration is being done per physician order and properly documented. By 06/15/16, licensed nursing staff were re-educated by thye NE on facility standards regarding medication administration, including not using single use medications for multiple residents. Newly hired clinical staff will receive this education by the NE/designee during the orientation process and at least annually. The Unit Managers/designee will observe medication administration practices compliance of one random nurse daily and document issues using a "Quality Assurance Review Audit" form for 12 weeks. Any negative findings are immediately corrected and then reported to the DON/designee. The Pharmacy Consultant or designee will monitor monthly through monthly medication pass reviews of at least one random nurse and report findings at monthly QAPI meeting. Issues will be immediately addressed and corrected as necessary. D. With Respect to How the Plan of Corrective Measures will be monitored:Issues and practice concerns will have appropriate action plans and interventions developed by the ADM/DON in conjunction with the QAPI Committee. Interventions include in services for the licensed nursing staff, a review of facility policies and procedures that relate to the aberrant practice and ongoing monitoring to assure the deficient practice does not recur. When current interventions are not producing the desired outcome, the ADM/DON in conjunction with the QAPI committee will develop alternate interventions until compliance is achieved.	06/15/16

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F 425	Continued From page 23 in-house Med Select (type of pharmacy back up) with the medications available. Continued interview confirmed the Charge Nurse failed to obtain the medications as directed.	F 431	F431 - DRUG RECORDS, LABEL/STORE DRUGS	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.		A. With respect to the Specific Residents Cited: The syringe of insulin cited was secured by the charge nurse #1 at time of survey on 05/09/16 and the Duoneb inhaler cited was secured by the charge nurse #3 at time of inquiry by the surveyor on 05/11/16. On 05/12/16, residents #183 and #184 were assessed by the DON/ designee for any adverse affects from the cited deficiency and no issues were identified. B. With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action: Residents receiving medication have the potential to be affected by the deficient practice allegation of failure to follow facility policy regarding medication storage and administration. An audit of the top of all medication carts and resident rooms was performed by the DON/designee and department heads through 05/12/16. Any issues identified were corrected. C. With Respect to What Systemic Measures have been put in place to address the Stated Concern: By 06/15/16, facility nurses (including Charge Nurses #1 and #3) were educated by the NE/designee on the importance of securely storing medications. Newly hired nurses will receive this education through the orientation process and at least annually. The DON/designee will inspect medication carts for proper medication storage weekly for 12 weeks. The Department Managers (DM) will observe medication storage practices during their daily rounds using the "Survey	06/15/16

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F 431	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on policy review, observation, medical record review, and interview the facility failed to ensure medications were secured and stored properly on 1 of 5 halls, and 1 of 4 resident rooms observed. The findings included: Review of the facility policy "...Storage of Medications...(not dated)" revealed, "...the medication supply is accessible only to licensed nursing personnel..." Observation on 5/9/16 at 8:10 PM revealed an unsecure syringe on top of the 200 hall medication cart. Continued observation revealed Charge Nurse #1 walked away from the medication cart down the end of the hall and entered a resident room. Observation revealed Certified Nursing Aide #2 approached surveyor when surveyor walked to medication cart. Interview and observation on 5/9/16 at 8:12 PM with Charge Nurse #1, on the 200 hall, revealed the unsecure syringe contained 22 units of Levemir (type of insulin) for Resident #184. Continued interview confirmed the medication was not stored correctly. Observation on 5/11/16 at 7:41 AM revealed Charge Nurse #3 administering medications. Continued observation revealed the Charge Nurse walked into resident #133's room to administer a breathing treatment. Observation	F 431	Preparedness Rounds " form and report any issues during the daily stand-up and stand down meetings. Audits will be conducted 5 times per week for 12 weeks, then randomly thereafter. The Pharmacy Consultant or designee will monitor monthly through monthly medication pass reviews and evaluate medication carts for stored medications and report findings at monthly QAPI meeting. Issues will be immediately addressed and corrected as necessary. D. With Respect to How the Plan of Corrective Measures will be monitored: Issues and practice concerns will have appropriate action plans and interventions developed by the ADM/DON in conjunction with the QAPI Committee. Interventions include in services for the licensed nursing staff, a review of facility policies and procedures that relate to the aberrant practice and ongoing monitoring to assure the deficient practice does not recur. When current interventions are not producing the desired outcome, the ADM/DON in conjunction with the QAPI committee will develop alternate interventions until compliance is achieved.	06/15/16

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F 431	Continued From page 25 revealed a Duoneb (type of inhalation medication) single vial container present on the resident over bed table. Interview with Charge Nurse #3 on 5/11/16 at 7:50 AM, on the 300 hall, confirmed the medication was not stored correctly. Interview with the Director of Nursing (DON) on 5/11/16 at 8:40 AM, in the DON office, confirmed the facility failed to follow the policy for medication storage.			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441	F441 - INFECTION CONTROL, PREVENT SPREAD, LINENS A. With respect to the Specific Residents Cited: Residents #183 and #184 were assessed by the DON/designee on 05/12/16, to identify any adverse effects from the cited deficiency of failure to use medication for single use only. No issues were identified, the attending MD was notified and no new orders were given and the residents and/or responsible parties were notified. B. With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action: Residents have the potential to be affected by the deficient practice allegation of failure to follow facility standards regarding infection control practices. An audit of medication pass infection control practices was done on 05/11/16 by the ADM and DON/designee. Any issues identified were immediately corrected by the ADM or DON/designee.	06/15/16

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F 441	Continued From page 26 from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observation, and interview the facility failed to ensure infection control was maintained during medication administration for 2 (Resident # 183, #184) of 4 residents observed for medication administration. The findings included: Review of the facility policy "...Insulin Administration...(not dated)" revealed, "...to be used for a single patient only..." Medical record review revealed Resident #183 was admitted to the facility on 5/2/16 with diagnoses including Heart Disease, Type 2 Diabetes Mellitus, and Chronic Obstructive Pulmonary Disease. Medical record review of the Physician Recapitulation orders dated May 2016 revealed "...Lantus (type of insulin) inject 70 units...at bedtime..."	F 441	C. With Respect to What Systemic Measures have been put in place to address the Stated Concern: On 5/11/16 Charge Nurse #1 was interviewed and counseled by the DON and NE on medication administration and infection control practices (including the requirement to use the in-house MedSelect system and/or backup pharmacy when a resident medication is not available and never use another resident's medication). On 05/12/16, the NE observed Charge Nurse #1 medication administration practices and documented the results on the "QAPI Daily Focused Rounds Form" to ensure that medication administration is being done per physician order and facility infection control standards. By 06/15/16, licensed nursing staff were re-educated by the NE or designee on facility standards regarding medication administration and infection control practices, including not using single use medications for multiple residents. Newly hired clinical staff will receive this education by the NE/designee during the orientation process and at least annually. The Unit Managers/designee will observe medication administration practices compliance of one random nurse weekdays and document issues using a "Quality Assurance Review Audit" form for 12 weeks. Any negative findings are immediately corrected and then reported to the DON/designee. The Pharmacy Consultant will monitor monthly through monthly medication pass reviews of at least one random nurse and report findings at monthly QAPI meeting. Issues will be immediately corrected as necessary.	06/15/16

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F 441	Continued From page 27 Medical record review revealed Resident #184 was admitted to the facility on 5/6/16 with diagnoses including Cellulitis, Type 2 Diabetes Mellitus, and Disorder of Kidney. Medical record review of the Physician Recapitulation orders dated May 2016 revealed "...Levemir (type of insulin) 30 units...at bedtime..." Observation on 5/9/16 at 8:10 PM, on the 100 hall, revealed Levimir available for use on top of medication cart for Resident #184. Continued observation on 5/9/16 at 8:24 PM, on the 100 hall, revealed Charge Nurse #1 obtained Lantus for Resident #183 from another resident. Interview with the Charge Nurse #1 on 5/9/16 at 8:32 PM, on the 100 hall, revealed the charge nurse obtained insulin for Residents #183 and #184 from other residents. Interview with the Director of Nursing (DON) on 5/10/16 at 9:02 AM, in the DON's office, confirmed the facility policy on insulin administration was not followed. Interview with the Pharmacy Consultant on 5/11/16 at 1:20 PM, in the DON's office, revealed the medications were available for use in the in-house pharmacy delivery system. Interview confirmed the medications should be for single patient use only.	F 441	D. With Respect to How the Plan of Corrective Measures will be monitored: Issues and practice concerns will have appropriate action plans and interventions developed by the ADM/DON in conjunction with the QAPI Committee. Interventions include in-services for the licensed nursing staff, a review of facility policies and procedures that relate to the aberrant practice and ongoing monitoring to assure the deficient practice does not recur. When current interventions are not producing the desired outcome, the ADM/DON in conjunction with the QAPI committee will develop alternate interventions until compliance is achieved.	06/15/16